CHAPTER IV

COVERED SERVICES AND LIMITATIONS

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FREEDOM OF CHOICE

Medicaid eligible individuals must be offered a choice of service provider(s). The individual's choice of providers is a federal requirement. Freedom of choice must be documented in the individual file of the recipient.

MEDALLION

MEDALLION is a mandatory Primary Care Case Management Program that enables Medicaid recipients to select their personal Primary Care Physicians (PCPs) who are responsible for providing and/or coordinating the services necessary to meet all of the recipient's health care needs. MEDALLION promotes the physician/patient relationship, preventive care and patient education while reducing the inappropriate use of medical services. The PCP serves as a care coordinator for access to most other non-emergency services that the PCP is unable to deliver through the normal practice of primary care medicine. The PCP must provide authorization for any other non-emergency, non-exempted services in order for another provider to be paid for services rendered. To provide services to a MEDALLION recipient, prior authorization from the recipient's PCP is required. Before rendering services, either direct the patient back to his or her PCP to request a referral or contact the PCP to inquire whether a referral is forthcoming. Please refer to the MEDALLION section of this manual for further details on the program.

MEDALLION II

In areas where the Medallion II program is available, many Medicaid recipients receive primary and acute care through mandatory enrollment in managed care organizations (MCOs). You will be able to identify recipients enrolled in a Medallion II MCO by their MCO Member Identification Card or by using the various Medicaid eligibility verification systems. Medicaid recipients enrolled in the traditional Medicaid program or MEDALLION program will have a regular Medicaid card. Except for family planning and emergency services, Medallion II recipients must utilize providers that participate within the MCO's provider network. Additionally, providers must adhere to the MCO's requirements regarding referrals and preauthorization, otherwise, payment for services may be denied. Providers may not bill the recipient for Medicaid covered services, including in those instances where a provider fails to follow the MCO's established guidelines.

Reference the section titled "Medallion II" in Chapter I of this manual for further details regarding individuals who are enrolled in Medallion II.

COVERED SERVICES

Rehabilitation services, both inpatient and outpatient, are covered services available to the entire Medicaid population. The physician is responsible for certifying that the service is medically necessary and that the treatment prescribed is in accordance with standards of medical practice. Medical necessity is defined as services ordered by a physician; a reasonable and medically necessary part of the recipient's treatment plan; consistent with generally accepted professional medical standards (i.e., not experimental or investigational); and furnished at a safe, effective, and cost-effective level.

PROVIDERS OF SERVICE

The Department of Medical Assistance Services (DMAS) provides coverage for physical rehabilitative services under two major programs: outpatient rehabilitation (physical and occupational therapies and speech-language pathology services), and intensive rehabilitative services. The outpatient rehabilitation program was implemented in 1978. Outpatient rehabilitation services may be provided in hospital outpatient settings of acute care and rehabilitation hospitals, rehabilitation agencies, home health agencies, and nursing facilities.

The intensive rehabilitation program was implemented in February 1986 to provide comprehensive rehabilitation services to the recipient that includes all of the following: rehabilitation nursing, physical therapy, occupational therapy, cognitive therapy, speech-language pathology services, social work services, psychology, therapeutic recreation, and durable medical equipment. These services may be provided by a freestanding rehabilitation hospital, a Comprehensive Outpatient Rehabilitation Facility (CORF), or by an acute care hospital that has a Medicare-exempt physical rehabilitation unit.

All rehabilitative services must be prescribed by a physician and be a part of a written plan of care/treatment plan that the physician reviews periodically. If a recipient is enrolled in the MEDALLION program and a specialist admits the recipient to rehabilitation, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP. Rehabilitation services are medically prescribed treatment for improving or restoring functions which have been impaired by illness or injury or, where function has been permanently lost or reduced by illness or injury, to improve the recipient's ability to perform those tasks required for independent functioning.

NOTE: To be reimbursed for services rendered, each provider must have a valid signed provider agreement with the Department of Medical Assistance Services for the type of services that are being provided.

INTENSIVE REHABILITATION SERVICES

Intensive rehabilitation program criteria and policy guidelines can also be found in the *Virginia Administrative Code*, 12VAC 30-50-225.

Admission Criteria (Including CORF)

A recipient is deemed to require either inpatient rehabilitation services or comprehensive

outpatient rehabilitation facility (CORF) services if both of the following criteria are met:

- An intensive rehabilitation program consisting of an interdisciplinary coordinated team approach is required to improve the recipient's ability to function as independently as possible; and

- Documentation exists that the rehabilitation program cannot be safely and adequately carried out in a less intensive setting (such as outpatient rehabilitation or home health services).

In addition to the above requirements, recipients must also meet all of the following criteria:

- The recipient requires rehabilitative nursing (for patient/family education and teaching in addition to skilled nursing care);

- The recipient requires at least two of the four listed therapies:

    - Physical Therapy
    - Occupational Therapy
    - Cognitive Therapy
    - Speech/Language Pathology Services;

- The recipient is able to actively participate in therapy on a daily basis;

- The medical condition is stable and compatible with an active rehabilitation program; and

- The recipient meets Interqual criteria upon admission. These criteria may be obtained through:

    McKesson Health Solutions LLC
    275 Grove Street
    Suite 1-110
    Newton, MA 02466-2273
    Telephone: 800-274-8374

    Fax: 617-273-3777
    website: mckesson.com or Interqual.com

Admissions for evaluation and/or training solely for vocational or educational purposes or for developmental or behavioral assessments are not covered services.

If during a previous hospital stay, an individual completed a rehabilitation program for essentially the same condition for which this admission is now being considered, reimbursement for the evaluation will not be covered unless a justifiable intervening circumstance necessitates a re-evaluation.

Special Circumstances

- DMAS may negotiate individual contracts with in-state or out-of-state intensive/comprehensive rehabilitation facilities for recipients with special intensive rehabilitation needs.

- The DMAS Long-Term Care and Quality Assurance Division will review intensive rehabilitation services requests for ventilator-dependent recipients and out-of-state placements. The contact for these services is the Facility and Home Based Services Unit at (804) 225-4222.

Guidelines for Initiating and Continuing Therapy

- Maintenance Therapy - Maintenance therapy is defined as the point where the recipient demonstrates no further significant improvement, or the skills of a qualified rehabilitative therapist are not required to carry out an activity or a home program to maintain functioning at the level to which it has been restored. Services in this category are not covered by Medicaid.

- Improvement of Function - Rehabilitative therapy designed to improve function must be based on an expectation that the therapy will result in a significant practical improvement in a recipient's level of functioning within a reasonable period of time. Where a valid expectation of improvement exists at the time the rehabilitative therapy program is implemented, the services would be recognized even though the expectation may not be realized. However, this would apply only up to the time at which it would have been reasonable to conclude that the recipient is not going to improve.

For continued intensive rehabilitation services, the recipient must demonstrate an ability to actively participate in goal-related therapeutic interventions developed by the interdisciplinary team. This shall be evidenced by regular attendance in interventions that are a part of the recipient's plan of care/treatment plan therapies and progression toward the established goals.

Discharge/Termination from Services

Intensive rehabilitation services must be considered for termination regardless of the preauthorized length of stay when any one of the following conditions are met:

- No further potential for improvement is demonstrated. The specialized knowledge and skills of a licensed/registered rehabilitative therapist are no longer required for safe and effective provision of such rehabilitation services. The recipient has reached his or her maximum progress and a safe and effective maintenance program has been developed;

- There is limited motivation on the part of the recipient or caregiver;

- The recipient has an unstable condition that affects his or her ability to participate in an intensive inpatient/comprehensive rehabilitative plan;

- Progress toward an established goal or goals cannot be achieved within a reasonable period of time;

- The established goals serve no purpose to increase functional or cognitive capabilities; and
- The service can be provided by someone other than a licensed or registered/certified rehabilitation professional.

Rehabilitation is a medically prescribed treatment for improving or restoring functions and must be considered for termination, regardless of the approved length of stay, when further progress toward the established rehabilitation goal is unlikely or further rehabilitation treatment can be achieved in a less intensive setting, such as in nursing facilities and outpatient agencies. Specifically, if no further progress is observed, discharge would be appropriate.

Therapeutic Furlough Days

- Properly documented rehabilitative reasons for furlough could occur as a part of an overall inpatient rehabilitation program. DMAS will not reimburse an inpatient rehabilitation provider for days when a recipient is on an overnight therapeutic furlough. Such days must not be billed or shown on the UB-92 invoice.

Transfer to Acute Care/Readmit to Rehabilitation

- When a recipient requires transfer to the acute care setting for more than 24 hours, the provider must discharge the recipient from the intensive rehabilitation program. When the recipient is medically stable and continued intensive rehabilitation services are appropriate, the recipient may be re-admitted from the acute care setting to continue the intensive rehabilitation.
- For all re-admissions after furloughs of more than 24 hours, each rehabilitation treatment team member must re-evaluate the recipient's functional status and record the findings in the recipient's medical record. In addition, each team member must review the current plan of care/treatment. Upon review of the plan of care/treatment, the team member must document whether or not changes to the current plan are necessary. This review of the plan of care must be signed and dated. The physician is responsible for documenting a re-admission note to review the events leading to the transfer and the appropriateness for the recipient to continue with the intensive rehabilitation program. For all readmissions after furloughs of more than 24 hours, whether or not plans of care have changed, preauthorization through the DMAS PA contractor is required.

PREAUTHORIZATION PROCESS FOR INTENSIVE REHABILITATION SERVICES

The purpose of preauthorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided.

Preauthorizations are specific to a recipient, a provider, a service code, an established quantity of units, and for specific dates of service. If preauthorization is required, preauthorization must be obtained regardless of whether or not Medicaid is the primary payer, except for Medicare-

crossover claims.

Preauthorization of intensive rehabilitation services must be obtained through the DMAS preauthorization (PA) contractor (effective February 17, 1997). All requests for preauthorization, as well as any information submitted in response to pend letters, must be directed to the DMAS PA contractor. The rehabilitation providers have the option of submitting preauthorization requests either telephonically or on paper. There may be circumstances where the provider will be required to submit written documentation in order to obtain preauthorization. All requests for preauthorization must be received by the DMAS PA contractor within 72 hours of admission. Requests received after 72 hours will be denied up to the day of the request. If the recipient continues to meet medical necessity criteria and is still in the facility, the DMAS PA contractor may approve the request beginning with the day of the request. DMAS will conduct utilization review visits for intensive rehabilitation providers and will strongly enforce the 72-hour notification policy. Failure to comply may result in the retraction of payment.

At the time of the admission review (within 72 hours of the admission to Intensive Rehabilitative services), the PA analyst will assign an initial length of stay and advise the representative for the provider that they must contact the DMAS PA contractor at least by the close of business on the last business day authorized. The DMAS PA analyst must advise the provider of the day and the date that continued stay review is required and document this in the DMAS PA contractor review database. If the provider fails to follow through with the continued stay review within the timeframe designated, dates of service not previously authorized should be denied up to the day that the provider contacts the DMAS PA contractor to conduct the review, whether by phone or fax. Denial Reason Code 3010 is to be used to deny authorization of the continued dates of service not requested within the time frames specified at the time of the previous review.

Failure to obtain a written initial physician certification (DMAS-127) upon admission to Intensive Rehabilitation Services may result in non-payment for services rendered. For a MEDALLION recipient, the written initial physician certification must be from the recipient's Primary Care Physician (PCP).

Preauthorization requests received without the written initial physician certification (DMAS-127) upon admission to Intensive Rehabilitation Services will be denied until the written certification is in the medical record.

The DMAS PA contractor utilizes InterQual Criteria as a guideline for determining medical necessity (effective November 1, 1997). Requests for preauthorization will be reviewed by the DMAS PA contractor and a determination made based on InterQual Criteria. If the request is approved, a length of stay will be assigned. Prior to the expiration of the previously assigned length of stay, the provider shall be responsible for obtaining preauthorization for continued intensive rehabilitation services. If continued stay is deemed medically necessary, an additional length of stay will be assigned. Concurrent review shall continue in the same manner until discharge of the recipient from intensive rehabilitation when services are deemed to be no longer medically necessary. Written notification of the PA analyst's decision will be mailed to the provider.

The DMAS PA contractor will not accept reviews for recipients who have Medicare Part A. If Medicare denies the requested stay, the provider may submit a preauthorization request for

retrospective review, along with the explanation of benefits (EOB) of denial. This request must be submitted to the DMAS PA contractor within 30 days of the Medicare denial.

Telephonic Preauthorization (PA) Requests

To make a telephonic PA request, providers must call the DMAS PA contractor within 72 hours of admission and provide the information requested to the DMAS PA analyst. The analyst will require information similar to the information described below, included on the PA request form. Additionally, the provider will need to verify that the required documentation and justification exists in accordance with federal and state regulations and DMAS published criteria, policy, and procedures.

While the provider is on the telephone, the PA analyst may assign the provider a treatment authorization number (billing number) for services that have been approved. The PA analyst may pend a request that requires further documentation in order to make a decision. Telephonic preauthorization requests must be made directly to the DMAS PA contractor at the following telephone numbers:

(804) 648-3159	Richmond Area
(800) 299-9864	All Other Areas

Paper Preauthorization Process

To make a paper preauthorization (PA) request, the Prior Review and Authorization Request (DMAS-351) must be fully completed and submitted for preauthorization. The information on the PA request form must be completed and submitted to the DMAS PA contractor within 72 hours of admission indicating a description of the admitting diagnoses, plan of care/treatment plan, expected progress, and a physician's certification/admission order that the recipient meets the admission criteria. Preauthorizations not received within 72 hours will not be approved until the preauthorization request is received by the DMAS PA contractor.

An exception to the 72-hour preauthorization requirement is in the case of retroactive eligibility. The facility must request preauthorization within 30 days of the notice of Medicaid eligibility determination. This request must be done in writing by mail.

The treatment authorization number (billing number) will not change for concurrent review unless the rehabilitation stay has been interrupted by a discharge of over 24 hours from a rehabilitation provider.

To submit a preauthorization request on paper, mail the PA request form and supporting documentation to the DMAS PA contractor. All providers must mail pend responses and reconsideration requests within 30 days directly to the DMAS PA contractor. The address is:

WVMI
6802 Paragon Place, Suite 410
Richmond, Virginia 23230

Direct all telephone inquiries regarding the preauthorization status concerning rehabilitation services to the provider HELPLINE at the telephone numbers listed in Chapter I of this manual. Information pertaining to preauthorization status is no longer available to other DMAS staff.

PROVIDER AND SERVICE REQUIREMENTS FOR INTENSIVE REHABILITATION

All practitioners and providers of services shall be required to meet current state and federal licensing and/or certification requirements as follows.

Physician

Physician services require that the physician have special knowledge and clinical skills and experience in the field of rehabilitation or other related fields. The physician must be licensed by the Virginia Board of Medicine. The recipient must be under the care of a physician who is legally authorized to practice and who is acting within the scope of his or her license.

The physician must meet all of the following requirements:

- Provide evidence of a written physician admission certification statement (DMAS-127) and physician recertification statement (DMAS-128) written every 60 days;
- Order rehabilitative therapy services to include specific procedures and modalities;
- Identify the specific discipline to carry out the plan of care/treatment plan;
- Indicate the frequency and duration of services (i.e.: 5x/week for 4 week estimated length of stay);
- Participate on a regular basis in treatment plan reviews and interdisciplinary team conferences;
- Consult with team disciplines as needed in providing a comprehensive approach of the treatment plan; and
- Provide evidence of a written review (DMAS-126) of the physician orders and plan of care/treatment plan every 60 days.

For recipients enrolled in MEDALLION: If a specialist admits the recipient to rehabilitation, the MEDALLION PCP must have made the referral to the specialist. The specialist must maintain documentation of coordination of services with the MEDALLION PCP.

Rehabilitative Nursing

Rehabilitative nursing services require nurses that have education, training, and/or experience which provides special knowledge and clinical skills to diagnose nursing needs and treat individuals who have health problems characterized by alteration in cognitive and functional ability. Rehabilitative nursing services are those services provided to a recipient which meet all of the following conditions:

- The services shall be directly and specifically related to an active written plan of care/treatment plan approved by a physician after any needed consultation with a registered nurse who is experienced in rehabilitation;

- The services shall be of a level of complexity and sophistication, or the condition of the recipient shall be of a nature that the services can only be performed by a registered nurse or licensed professional nurse, nursing assistant, or rehabilitation technician under the direct supervision of a registered nurse who is experienced in rehabilitation;

- The services shall be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or shall be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services shall be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice and include the intensity of rehabilitative nursing services, which can only be provided in an intensive rehabilitative setting.

Physical Therapy

Physical Therapy services are those services provided to a recipient that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by a physician after any needed consultation with a physical therapist (PT) licensed by the Virginia Board of Physical Therapy (effective September 27, 2000). The *Code of Federal Regulations* (42 CFR 440.110) require that the therapist meet licensure requirements within the scope of the practice under State law;

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by a physical therapist licensed by the Virginia Board of Physical Therapy (effective September 27, 2000) or a physical therapy assistant, who is licensed by the Virginia Board of Physical Therapy (LPTA), under the direct supervision of a qualified physical therapist licensed, as defined above;

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Note: Physical therapy that can be performed by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.), does not meet DMAS criteria for reimbursement as physical therapy services. There is no provision for Medicaid reimbursement for students rendering therapy services.

Only a licensed physical therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function, determine whether a physical therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a licensed physical therapist (PT) are required to evaluate the recipient's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a licensed physical therapy assistant (LPTA) functioning under the direct supervision of a licensed physical therapist. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the licensed physical therapist (not the LPTA). When services are provided by an LPTA, the PT must conduct a supervisory visit at least every 30 days while therapy is being conducted and document accordingly.

If an adequate number of qualified personnel are not available to carry out the physician order, particularly related to the frequency of service, the therapist will inform the physician of this fact and record the response of the physician in the medical record. The plan of care will be revised accordingly with physician written approval.

Generally, physical therapy is not required to improve or restore function where a recipient suffers a temporary loss or reduction of function (e.g., temporary weakness which may follow prolonged bed rest following major abdominal surgery) that could reasonably be expected to spontaneously improve as the recipient gradually resumes normal activities. Physical therapy for temporary loss of function will not be covered.

The more common physical therapy modalities and procedures are illustrated as follows. These applications are appropriate for intensive rehabilitation services and for outpatient rehabilitation services.

Gait Training

Gait evaluation and training provided to a recipient whose ability to walk has been impaired by neurological, muscular, or skeletal abnormality requires the skills of a licensed physical therapist and constitutes physical therapy, provided that it can reasonably be expected to significantly improve the recipient's ability to walk.
Examples of services that do not constitute rehabilitation physical therapy are:

- Repetitious exercises to improve gait, maintain strength, endurance, and assistive walking (such as provided in support for feeble or unstable patients);

- Activities appropriately provided by supportive personnel (e.g., aides or nursing staff); and

- Activities that do not require the skills of a licensed physical therapist or licensed physical therapist assistant.

Range of Motion

Range of motion exercises constitute physical therapy only when they are part of the active treatment of a specific diagnosis that has resulted in a loss or restriction of mobility as evidenced by physical therapy notes showing the degree of motion lost and the degree to be restored. Only a licensed physical therapist may perform range of motion tests, and, therefore, such tests constitute physical therapy. Range of motion exercises, whether because of their nature or the condition of the recipient, which may be performed safely and effectively only by a licensed physical therapist, or a licensed physical therapy assistant under the direct supervision of a therapist, will be considered rehabilitation therapy that is reimbursed.

Range of motion exercises not related to the restoration of a specific loss of function can ordinarily be provided safely by supportive personnel (such as physical therapy aides, nursing staff, volunteers, etc.), and do not require the skills of a licensed physical therapist or licensed physical therapy assistant. Passive exercises to maintain range of motion in paralyzed extremities, can be carried out by physical therapy aides or nursing staff, and will not be considered rehabilitation therapy and, therefore, are not reimbursed.

Ultrasound, Shortwave, and Microwave Diathermy Treatments

These modalities must always be performed by or under the direct supervision of a licensed physical therapist and, therefore, constitute covered physical therapy.

Therapeutic Exercises

Therapeutic exercises (e.g., strengthening, stretching, tilt table activities, etc.), performed by or under the direct supervision of a licensed physical therapist due to either the type of exercise employed or the condition of the recipient constitute covered physical therapy and can be reimbursed.

Hot Pack, Hydrocollator, Infrared Treatments, and Whirlpool Baths

The skills, knowledge, and judgment of a licensed physical therapist may be required in giving such treatments or baths (e.g., where the recipient's condition is complicated by circulatory deficiency, areas of desensitization, open wounds, or other complications).

Occupational Therapy

Occupational therapy services are those services provided to a recipient that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by the physician after any needed consultation with an occupational therapist registered and licensed (OTR) by the National Board for Certification in Occupational Therapy and licensed by the Virginia Board of Medicine. The *Code of*

Federal Regulations (42 CFR 440.110) requires that the therapist meet licensure requirements within the scope of the practice under state law;

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by an occupational therapist registered and licensed, as defined above, *or* an occupational therapy assistant (COTA) certified by the National Board for Certification in Occupational Therapy under the direct supervision of a qualified occupational therapist, as defined above;

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonably and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practices; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Note: Occupational therapy that can be performed by supportive personnel (such as occupational therapy aides, nursing staff, volunteers, etc.), does not meet DMAS criteria for reimbursement as occupational therapy services. There is no provision for Medicaid reimbursement for students rendering therapy services.

Only a registered and licensed occupational therapist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether an occupational therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a registered and licensed occupational therapist are required to evaluate the recipient's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by a certified occupational therapy assistant (COTA) functioning under the direct supervision of a registered and licensed occupational therapist. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. The plan of care/treatment plan must be developed and signed by the registered and licensed occupational therapist (not the COTA). When services are provided by a COTA, the OTR must conduct a supervisory visit at least every 30 days while therapy is being conducted and document accordingly.

If an adequate number of qualified personnel are not available to carry out the physician order, particularly related to the frequency of service, the therapist will inform the physician of this fact and record the response of the physician in the medical record. The plan of care will be revised accordingly with physician written approval.

Occupational therapy may involve some or all of the following procedures:

- The evaluation and re-evaluation, as required, to assess a recipient's level of function by administering diagnostic and prognostic tests;

- The selection and teaching of task-oriented therapeutic activities designed to restore physical function (e.g., use of woodworking activities on an inclined table to restore shoulder, elbow, and wrist range of motion lost as a result of burns or injury);

- The planning, implementing, and supervising of an individualized therapeutic activity program as part of an overall active treatment program (e.g., the use of computer activities that require following multi-level directions, assist with memory loss and reality orientation in a neurologically impaired recipient);

- The planning and implementing of therapeutic tasks and activities to restore sensory-integrative function (e.g., providing motor and tactile activities to increase sensory input and improve response for a stroke recipient with functional loss resulting in a distorted body image); and

- The teaching of compensatory techniques to improve the level of independence in the activities of daily living (e.g., teaching a recipient who has lost the use of an arm dressing and cooking skills with one hand, teaching an upper extremity amputee how to functionally utilize a prosthesis, or teaching a spinal cord injured recipient new techniques to enable him or her to perform feeding, toileting, and other activities as independently as possible).

Speech-Language Pathology

Speech-language pathology services are those services provided a recipient that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by a physician after any needed consultation with a speech-language pathologist licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology. The *Code of Federal Regulations* (42 CFR § 440.110) require that the therapist meet licensure requirements within the scope of the practice under state law;

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by any one of the following:

- A Masters level prepared speech-language pathologist (SLP) licensed by the Virginia Department of Health Professions, Virginia Board of Audiology and Speech-Language Pathology; or

- An individual licensed by the Virginia Board of Audiology and Speech-Language Pathology who meets one of the following:

  a) Has a Certificate of Clinical Competence (CCC) from the American Speech and Hearing Association (ASHA); or

  b) Has completed the Masters level academic program and is acquiring supervised work

experience to qualify for the ASHA certification.

This individual is in the Clinical Fellowship Year (CFY), typically a nine-month supervision. This individual must be under the direct supervision of a licensed CCC/SLP or SLP. Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. When services are provided by a CFY/SLP, a licensed CCC/SLP or SLP must make a supervisory visit at least every 30 days while therapy is being conducted and document accordingly;

c) DMAS will reimburse for the provision of speech-language services when provided by an individual identified by DMAS as a speech-language assistant, e.g., a Bachelors level, a Masters level without licensure by the Board of Audiology and Speech Language Pathology, or a Masters level with licensure only by the Department of Education (effective January 1, 2001) (DMAS identifies any person who does not meet the qualifications required for billing DMAS as a speech-language assistant). The identity of the unlicensed assistant (and the fact that they do not meet qualification requirements to bill Medicaid) shall be disclosed to the recipient, parent, or legal guardian prior to treatment, and this disclosure shall be documented and made a part of the recipient's record. These speech-language assistants must be under the direct supervision of a licensed CCC/SLP or SLP that meets DMAS' licensure requirements.

Direct supervision by a qualified therapist includes initial direction and periodic observation of the actual performance of the therapeutic activity. When services are provided by a CFY/SLP or a speech-language assistant, a licensed CCC/SLP or SLP must make a supervisory on-site visit at least every 30 days while therapy is being conducted. The supervisory therapist is not required to co-sign the speech-language assistant's progress visit notes; however, he or she is required to review the notes. If the supervisory therapist co-signs the assistant's progress visit notes, this does not constitute a 30-day supervisory visit note. Evidence of the supervisory therapist on-site visit must be documented every 30 days in the medical record.

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

> Note: Speech-language pathology services that can be performed by supportive personnel (such as speech aides, nursing staff, volunteers, etc.), does not meet DMAS criteria for reimbursement as speech-language pathology services. There is no provision for Medicaid reimbursement for students rendering therapy services.

Only a licensed speech-language pathologist has the knowledge, training, and experience required to evaluate and, as necessary, re-evaluate a recipient's level of function; determine whether a speech therapy program could reasonably be expected to improve, restore, or compensate for lost function; and, where appropriate, recommend to the physician a plan of care/treatment plan. However, while the skills of a licensed speech-language pathologist are required to evaluate the recipient's level of function and develop a plan of care/treatment plan, the implementation of the plan may be carried out by one of the following: SLP, CCC/SLP, and CFY/SLP, and speech-language assistants as identified above. The plan of care/treatment plan must be developed and signed only by the licensed speech-language pathologist.

If an adequate number of qualified personnel are not available to carry out the physician order, particularly related to the frequency of service, the therapist will inform the physician of this fact and record the response of the physician in the medical record. The plan of care will be revised accordingly with physician written approval.

Speech-language pathology services include the following procedures:

- Assistance to the physician in evaluating patients to determine the type of speech or language disorder and the appropriate corrective therapy, such as an assessment by a speech-language pathologist of a recipient with aphasia following a recent stroke to determine the need for speech-language pathology services.
- Providing rehabilitative services for speech and language disorders.
- Providing rehabilitative services for swallowing disorders, cognitive problems, etc.

Reimbursement for speech-language pathology services is limited to those services related to a medical diagnosis. Long-term speech-language pathology services, such as may be requested for a recipient with a long-term speech impairment, are not covered under intensive rehabilitation.

Cognitive Rehabilitation Therapy

The provision of cognitive rehabilitation is included in *the State Plan for Medical Assistance* as a component of rehabilitation for severely neurologically impaired individuals, such as those with traumatic brain injury (TBI). Other diagnoses that may require cognitive remediation include, but are not limited to, severe cerebral vascular accident (CVA), anoxic injuries, and intracranial hemorrhage. For these diagnoses, as well as for TBI, major impairments exist in arousal or alerting, perception, selective attention, discrimination, orientation, organization, recall, and high level thought processes, including convergent thinking, deductive reasoning, inductive reasoning, divergent thinking, and multi-process reasoning.

Cognitive rehabilitation services are those services furnished a recipient that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan designed by the physician after any needed consultation with a clinical psychologist (i.e., Ph.D. or Psy.D.) or physician experienced in working with the neurologically impaired and licensed by the Virginia Board of Medicine;

- The services must be of a level of complexity and sophistication or the condition of

the recipient must be of a nature that the services can only be performed by a clinical psychologist or physician experienced in the administration of neuropsychological assessments and licensed by the Virginia Board of Medicine and in accordance with a plan of care/treatment plan based on the findings of the neuropsychological evaluation;

- Cognitive rehabilitation therapy services may be provided by occupational therapists, speech-language pathologists, and master's level psychologists with experience in working with the neurologically impaired when provided under a plan of care/treatment plan recommended and coordinated by a physician or clinical psychologist licensed by the Virginia Board of Medicine. The plan of care/treatment plan must be prepared with the assistance and input of any specialist who may be called upon to provide services pursuant to the plan.

- The licensed clinical psychologist or the physician must provide supervision of the SLP, OT, and/or the master's level psychologist. The plan of care must be reviewed by the licensed clinical psychologist or the physician with the treating therapist and revised as needed, but at least every 30 days.

  When the treating therapist is working with the patient, if consultation is needed, the licensed supervising psychologist or the physician must be available or accessible. Evidence of the supervisory visit must be documented at least every 30 days in the medical record.

- The cognitive rehabilitation services must be an integrated part of the total recipient care plan and must relate to information processing deficits that are a consequence of and related to a neurologic event;

- The cognitive rehabilitation services include activities to improve a variety of cognitive functions such as orientation, attention/concentration, reasoning, memory, discrimination, and behavior; and

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis.

Psychology

Psychology services are those services provided a recipient that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan ordered by a physician;

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by a

qualified clinical psychologist (Ph.D. or Psy.D.), or by a clinical social worker (LCSW), or a professional counselor (LPC); or a clinical nurse specialist-psychiatric, all licensed and certified by the appropriate Board under the Department of Health Professions;

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to the establishment of a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Social Work

Social work services are those services provided a recipient that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan ordered by a physician;

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by a qualified licensed social worker as required by the Virginia Department of Health Professions, Board of Social Work;

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Therapeutic Recreation

Therapeutic recreation services are those services provided a recipient that meet all of the following conditions:

- The services must be directly and specifically related to an active written plan of care/treatment plan ordered by a physician;

- The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services are performed as an integrated part of a comprehensive rehabilitation plan of care by a therapeutic recreation specialist certified with the National Council for Therapeutic Recreation at the professional level;

- The services must be provided with the expectation, based on the assessment made by the physician of the recipient's rehabilitation potential, that the condition of the recipient will improve significantly in a reasonable and generally predictable period of time, or the services must be necessary to establish a safe and effective maintenance program required in connection with a specific diagnosis; and

- The services must be specific and provide effective treatment for the recipient's condition in accordance with accepted standards of medical practice; this includes the requirement that the amount, frequency, and duration of the services must be reasonable.

Prosthetic/Orthotic Services

Prosthetic services furnished to a recipient include prosthetic devices that replace all or part of an external body member and services necessary to design the device, including measuring, fitting, and instructing the recipient in its use. Refer to the *Physician Manual* for further information.

Orthotic device services furnished to a recipient include orthotic devices that support or align extremities to prevent or correct deformities or to improve functioning, as well as services necessary to design the device, including measuring, fitting, and instructing the recipient in its use. Refer to the Medicaid *DME and Supplies Manual* for further information.

Coverage is available for medically necessary prosthetic/orthotic services, when recommended as part of an approved intensive rehabilitation program, when the following criteria are satisfied via adequate and verifiable documentation: prosthetics/orthotics shall be ordered by the physician; and directly and specifically related to an active, written, and physician-approved treatment or discharge plan.

Durable Medical Equipment

Durable medical equipment (DME) and supplies required for use during the course of the rehabilitation stay are included in the per diem rate, and are entered on the rehabilitation hospital bill as ancillary services.

Durable Medical Equipment required for in home use or to facilitate the recipient's discharge home or to an Adult Care Residence (not to an extended care facility) may be covered under the DME and supplies program. (Reference the *Nursing Home Manual* for DME coverage guidelines for recipients who reside in or will be discharged to an extended care facility).

Durable Medical Equipment and Supplies Program

Medicaid payment is made to DME providers who have an agreement of participation with DMAS and are in compliance with established policies and procedures as described in the Medicaid *DME and Supplies* Manual. Only supplies, equipment, and appliances that are determined medically necessary may be covered for reimbursement by DMAS. DME and supplies must be physician ordered on the DMAS-352, Certificate of Medical Necessity (CMN) form. Coverage is limited to DME and supplies that are a reasonable and medically necessary part of the recipient's treatment plan; consistent with the recipient's diagnosis, functional limitations, and symptoms; and furnished at a safe, effective, and cost-effective level suitable for use in the recipient's home environment. DME providers must adhere to the specific coverage criteria as detailed in the Medicaid *DME and Supplies* Manual.

DME Preauthorization

Unusual amounts, types, and duration of DME usage must be preauthorized by DMAS preauthorization contractor. When determined to be cost-effective, DMAS preauthorization contractor may authorize rental of the equipment in lieu of purchase. Requests for preauthorization should be coordinated with the physician and DME provider prior to the acquisition of the equipment. Refer to the *DME and Supplies Manual* issued by DMAS for specific preauthorization requirements.

PREAUTHORIZATION RECONSIDERATIONS and APPEALS PROCESS

If intensive rehabilitation services are denied by the preauthorization (PA) analyst and the intensive rehabilitation provider wants to request reconsideration of the denial, the provider must follow the reconsideration process. If a telephone request is denied, the provider may either request telephonic or written reconsideration from the DMAS PA contractor Outpatient Review Services Supervisor within 30 days of the date of the denial. The Outpatient Review Services Supervisor has the option of requiring written reconsideration of a telephone preauthorization request. To request a reconsideration of a denied request, the provider must submit a letter of reconsideration within 30 days of the notice of denial, to:

WVMI
Outpatient Review Services Supervisor
6802 Paragon Place, Suite 410
Richmond, Virginia 23230

After completion of the reconsideration process, the denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the preauthorization denial is for a service that has already been rendered, the provider may appeal the denial in writing within 30 days of the written notification of denial of the reconsideration. Written appeals must be addressed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Recipient Appeals

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS or the PA contractor.

If the denied intensive rehabilitation service has not been provided, the denial may be appealed by the recipient or by the recipient's authorized representative. For additional information on recipient appeals, refer to the appeals section of Chapter VI of this manual.

OUTPATIENT REHABILITATION SERVICES

Outpatient rehabilitation program criteria and policy guidelines can also be found in 12 VAC 30-50-200.

Admission Criteria

Eligibility for general outpatient rehabilitative services is based on the recipient's medical need for one or more of the following covered services: physical therapy, occupational therapy, or speech-language pathology services. A physician must prescribe these services. If a recipient is enrolled in the MEDALLION program and a specialist admits the recipient to rehabilitation, the MEDALLION PCP must have made the referral to the specialist. This referral may be obtained in writing or orally and must be documented in the recipient's medical record. The specialist must maintain documentation of coordination of services with the MEDALLION PCP. Rehabilitation services are medically prescribed treatment for improving or restoring functions that have been impaired by illness or injury, or where function has been permanently lost or reduced by illness or injury, to improve the individual's ability to perform those tasks required for independent functioning. Rehabilitation services for speech impairments secondary to developmental delays, autism, and other related communication disorders are also covered services.

Admissions for evaluation and/or training solely for vocational or educational purposes or for developmental or behavioral assessments are not covered services.

Any one of these therapy services may be offered as the sole rehabilitative service and shall not be contingent upon the provision of another service. Medicaid covers general outpatient rehabilitative services provided in outpatient settings of acute and rehabilitation hospitals, nursing facilities, and rehabilitation agencies. All providers must have a provider agreement with the Department of Medical Assistance Services (DMAS).

All practitioners and providers of services shall be required to meet state and federal licensing and certification requirements. Services not specifically documented in the recipient's medical

record as having been rendered shall be deemed not to have been rendered, and no payment shall be provided.

Definition of a Visit

A visit is defined as the treatment session that a rehabilitation therapist is with a client to provide covered services prescribed by a physician. **Visits are not defined in measurements or increments of time.** Reimbursement is made on a per visit basis. The furnishing of any services by a rehabilitation therapist on a particular day or a particular time of day constitutes a visit. For example, if both a physical therapist and an occupational therapist furnish services on the same day, this constitutes two visits - one each of physical therapy and occupational therapy. If a therapist furnishes several services during a visit, this constitutes only one visit. However, if a therapist provides two distinctly separate therapy sessions in the same day (e.g., a morning session and an afternoon session), this would constitute two visits.

Combined visits by more than one therapist cannot be billed as separate visits if the goal(s) of the therapists is the same for that visit (e.g., two therapists are required to perform a single procedure). The overall goal(s) of the sessions determines how the visit can be billed.

Recipient Co-payments

Co-payments are the same for categorically needy recipients, Qualified Medicare Beneficiaries (QMBs), and medically needy recipients. For the purpose of co-payments, a visit is defined as a patient encounter in the same place of treatment, by the same provider, on the same day, regardless of the number of procedures or visits performed during the same day.

The co-payments and applicable amounts for rehabilitation are as follows:

- Inpatient rehabilitation hospital: $100.00 co-pay per admission
- Outpatient rehabilitation service (including CORF): $3.00 co-pay per visit

The co-payments apply to all recipients except for the following:

- Children under 21 years of age; and
- Individuals receiving long-term care services or hospice services.

The following services are never subject to co-payments:

- Emergency services;
- Family planning services; and
- Pregnancy-related services (i.e., services delivered to pregnant women if such services are related to the pregnancy or to any other medical condition, which may complicate the pregnancy, such as prenatal, delivery, postpartum care).

Services to a recipient cannot be denied solely because of his or her inability to pay any applicable co-payment charge. This does not relieve the recipient of the responsibility to pay, nor does it prevent the provider from attempting to collect any applicable co-payment from the recipient.

Coordination of Rehabilitation Services

The purpose of coordination of services is to maximize therapy benefits for the recipient. Coordination of services between treating therapists must be done when a recipient receives therapies from two separate rehabilitation providers (i.e., school and after-school therapies). Coordination of services allows two treatment therapists to assure maximum benefit of services is achieved for the recipient based on the treatment plans. Therapists do have a professional responsibility to keep physicians and families informed of each patient's rehabilitation progress. In addition, coordination of services may prevent duplication of services. Coordination of services will be reviewed by the DMAS PA contractor through the preauthorization process and by DMAS for compliance during utilization review activities.

If the recipient is enrolled in MEDALLION, there must be a referral for the service from the MEDALLION primary care physician (PCP). This referral may be obtained in writing or orally and must be documented in the recipient's record.

Duplication of services is defined as two treatment plans from two separate rehabilitation providers that are identical. However, there may be instances when there are some similar recipient goals, but the recipient requires a frequency/intensity of services that one provider cannot address. For example, if a recipient has speech-language needs in school that are appropriately addressed by the school therapist, but he also requires additional speech therapy after school, then the school therapist and a community therapist need to coordinate services to assist the recipient toward meeting the recipient's treatment goals. When two separate rehabilitation providers are not coordinating services, the treatment plans may be in conflict with the desired recipient outcome.

Payment will be retracted for any duplication of services as a result of DMAS utilization review.

Categorization of Two Subgroups: Acute vs. Non-Acute Conditions

There are two subgroups in general outpatient rehabilitation: acute conditions and long-term, non-acute conditions.

- **Acute conditions** are defined as those conditions which are expected to require rehabilitative services for a duration of less than twelve (12) months, and in which progress toward established goals is likely to occur frequently.
- **Long-term, non-acute conditions** are defined as those conditions which are expected to require rehabilitative services for a duration of greater than twelve (12) months, and in which progress toward established goals is likely to occur slowly.

If the recipient is appropriate for the acute sub-group, requiring rehabilitative services for less than twelve (12) months, a physician re-certification (renewal of orders and plan of care/treatment plan) is required at least every sixty (60) days. Any initial plan of care/treatment plan or periodic renewal written by the qualified therapist must be signed and dated by the physician within 21 days of implementation of the plan. See "EXHIBITS" at the end of this chapter for the optional Outpatient Rehabilitation Plan of Care and Outpatient Rehabilitation Plan of Care Addendum forms, which rehabilitation providers may use.

If the recipient is appropriate for the long-term, non-acute sub-group, requiring rehabilitative services for greater than twelve (12) months, a physician re-certification (renewal of orders and plan of care/treatment plan) is required at least annually. The physician must sign and date the order/plan of care/treatment plan at the time of review/renewal prior to the initiation of the continuation of service.

Defining a condition as acute or as long-term, non-acute, is not based on an individual's diagnosis. Defining the condition is based on the length of time services are medically justified. The requirement for the development of an appropriate and realistic plan of care/treatment plan remains unchanged. Plans of care/treatment plans must still include measurable, long-term goals with anticipated dates of achievement. Plans of care/treatment plans must be renewed by the physician at any time long term goals are achieved or are in need of revision, regardless of the subgroup categorization of the individual recipient.

Home Therapies

Licensure requirements in the State of Virginia provide that only agencies that are licensed as home care organizations may provide services in the home. An exception is providers of service for children enrolled with the Early Intervention program (Part C of IDEA) are not required to be licensed as home care organizations. [Code of Virginia, Section 2.2-5308]

If an outpatient rehabilitation agency is contracting with a school district to provide rehabilitation services to special education children in accordance with the IEP (Individualized Education Program), which identifies home-based instruction and rehabilitation therapy services, then home therapies may be provided by the outpatient rehabilitation provider. [8 VAC (Virginia Administrative Code) 20-131-180 and 8 VAC 20-80-10]

School districts under contract with outpatient rehabilitation providers must bill DMAS for all rehabilitation services provided to Medicaid recipients with an IEP (effective July 1, 2002).

Therapies Provided in Nursing Facilities

DMAS provides direct reimbursement to enrolled rehabilitation providers for outpatient therapies rendered to recipients residing in nursing facilities. This reimbursement shall not be provided for any sums that the rehabilitation provider collects, or is entitled to collect, from the nursing facility or any other available source. In addition, it shall in no way diminish any obligation of the nursing facility to provide its residents such services, as set forth in any applicable provider agreement.

Rehabilitative Services in ICF/MR Facilities

When skilled rehabilitative services are appropriately provided directly to the Medicaid recipient in an intermediate care facility for the mentally retarded (ICF/MR), they may be billed to Medicaid by the outpatient rehabilitation provider. When reasonable and necessary skilled rehabilitative services are provided to residents of the facility (i.e., staff instruction and program monitoring), they are not billable to Medicaid for a specific resident; however, they are considered an administrative cost and must be billed to the ICF/MR. Reasonable and necessary administrative costs will be considered under the cost settlement process for the ICF/MR.

Other Rehabilitation Therapy Programs

All rehabilitation programs must meet DMAS criteria no matter what the particular focus of the treatment program (cardiac rehabilitation, pulmonary rehabilitation, pain management, etc.). The services must be of a level of complexity and sophistication or the condition of the recipient must be of a nature that the services can only be performed by a licensed physical or occupational therapist (PT or OT). These services must be directly and specifically related to an active written treatment plan of care designed by a physician after any needed consultation with a licensed therapist. The treatment program must address significant improvement of functional ability, mobility, and endurance, and not simply performing repetitious exercises.

Pool therapy, another rehabilitation program, is a covered service when provided in conjunction with a treatment plan that requires the skills of a licensed therapist. For example, water aerobics classes would not be a covered service unless the above-described criteria are met.

Therapist Qualifications and Therapy Modalities

Qualifications for physical therapists, occupational therapists, and speech-language pathologists, as well as therapy modalities and treatment procedures are defined in this chapter under the intensive rehabilitation section.

Therapy Guidelines

The following are guidelines designed to assist with determination of appropriate services:

- **Improvement of Function** - Rehabilitative therapy designed to improve function must be based on an expectation that the therapy will result in a significant practical improvement in a recipient's level of functioning within a reasonable period of time. Where a valid expectation of improvement exists at the time the rehabilitative therapy program is instituted, the services will be recognized even though the expectation may not be realized. However, this would apply only up to the time at which it would have been reasonable to conclude that the recipient is not going to improve.

- **Maintenance Therapy** - Maintenance therapy is defined as the point where the recipient demonstrates no further significant improvement, or the skills of a qualified rehabilitative therapist are not required to carry out an activity or a home program to maintain function at the level to which it has been restored. Services in this category are non-covered.

- **Duplicative Services -** Duplicative services are not considered medically justified and will not be covered by DMAS. An inquiry or referral for services does not indicate the necessity for services. If the Medicaid recipient is receiving services from another provider, it is the responsibility of the evaluating provider to determine if additional services are appropriate. If both providers are working on goals to meet the same functional needs and providing comparable services (such as in-

school therapies and after-school therapies), only one provider will be reimbursed. If two providers have provided duplicative services during the same time period, the provider that initially treated the recipient will be reimbursed. Coordination of recipient care between all health care professionals should be evident in the recipient's record. Services that are included in other DMAS program visits will not be covered (i.e., equipment repairs).

Termination of Outpatient Physical Therapy, Occupational Therapy, or Speech-Language Pathology Services

Outpatient physical therapy, occupational therapy, or speech-language pathology services must be considered for termination when further progress toward the established goals is unlikely or it is appropriate to assume that therapy treatments can be maintained or provided by the recipient, family, caregiver, etc. In these instances, DMAS will not reimburse for services. Specifically, if no further progress is observed, discharge is appropriate. The physician must sign and date all orders for discharge.

PREAUTHORIZATION FOR OUTPATIENT REHABILITATION SERVICES

Service Limitations

Physical therapy, occupational therapy, and speech-language pathology services shall be limited to five (5) visits per rehabilitative discipline annually (effective July 1, 2003). The initial therapy evaluation is included in the 5 visits. Visits include those services provided by outpatient settings of acute and rehabilitation hospitals, nursing facilities, rehabilitation agencies, and home health agencies. Limits are specific per discipline and recipient, regardless of the number of providers rendering services. "Annually" is defined as July 1 through June 30. The provider must maintain documentation to justify the need for services. Preauthorization by DMAS preauthorization is required before payment will be made for any visits over 5 annually.

If the recipient is enrolled in MEDALLION, services may not be provided without a referral from the Primary Care Physician (PCP). A referral may be requested in writing or via telephone from the recipient's PCP.

Evaluations must be related to the admission to service, to readmission to service, or to a significant change in the condition of the recipient and is not provider-program mandated.

Preauthorization for extended services shall be based on individual need. Providers must request an extension to the preauthorization prior to the last authorized day. Reimbursement shall not be made for additional services unless the extended provision of services has been preauthorized. Care rendered beyond the 5th visit allowed annually which has not been preauthorized shall not be approved for reimbursement.

If a provider wants to request information about the service limits, he or she may contact the DMAS provider help line at 1-800-552-8627.

Preauthorization Process

The purpose of preauthorization is to validate that the service being requested is medically necessary and meets DMAS criteria for reimbursement. Preauthorization does not automatically guarantee payment for the service; payment is contingent upon passing all edits contained within the claims payment process; the recipient's continued Medicaid eligibility; and the ongoing medical necessity for the service being provided. Preauthorizations are specific to a recipient, a provider, a revenue code, units, and for specific dates of service. If preauthorization is required, preauthorization must be obtained whether or not Medicaid is the primary payer, except for Medicare-crossover claims.

The preauthorization of outpatient rehabilitation services must be obtained through the DMAS preauthorization contractor, (effective February 17, 1997). All preauthorization requests, as well as any information submitted in response to pend letters, must be directed to the DMAS preauthorization contractor. Preauthorization may be obtained only by calling the DMAS preauthorization prior to the completion of the 5th visit. The DMAS preauthorization contractor may request that certain documentation or an entire request be faxed. Telephonic preauthorization must be obtained prior to rendering services in order to receive reimbursement. Any service provided without preauthorization and in excess of the 5th visit limitation will not be reimbursed. In the event that treatment has continued with a lapse in authorizations, authorization may begin on the day it is requested if the criteria are met. Any services provided without preauthorization will not be reimbursed.

Direct all telephone inquiries regarding the preauthorization status concerning rehabilitation services to the provider HELPLINE at the telephone numbers listed in Chapter I of this manual. Information pertaining to preauthorization status is no longer available to other DMAS staff.

DMAS preauthorization contractor will not accept reviews for recipients who have Medicare Part B. If Medicare denies the requested stay, the provider may submit a request in writing for preauthorization as a retrospective review. This must be submitted to the DMAS preauthorization contractor within 30 days of the notice of denial by Medicare.

A request for retrospective review may be submitted by paper or fax to the addresses or telephone numbers listed in this chapter. The justification for requesting retrospective review must be stated on the request.

In conjunction with the decreased service limits (effective July 1, 2003), DMAS has changed the initial review process at the start of care. The DMAS preauthorization contractor may request additional information to determine if this request meets DMAS criteria. These changes to the preauthorization process do not eliminate any documentation requirements stated by DMAS. These documentation requirements will be reviewed on post payment review.

Detailed documentation to address medical necessity, including discharge planning, must be submitted with each plan of care. The DMAS contractor reviews this information to determine if the request meets DMAS criteria for the initiation and continuation of care.

Initial Review

If preauthorization (PA) is requested before or at the initiation of services, the provider may request PA using the physician's order for services. The PA analyst may approve up to 7 days (up to 5 visits). Prior to the end of the last authorization date, or the next visit, the provider must submit the therapist's evaluation. DMAS or the PA contractor will make a decision based upon documentation provided and program guidelines to approve, pend, deny, or reject the request. If the request is approved, DMAS or the PA contractor will authorize a specific number of units and dates of service.

If PA is requested after the initiation of services but prior to the 5th visit, the physician order and therapist evaluation will be required for review. If DMAS criteria and program guidelines are met, authorization will be granted. Visits provided prior to the 5th visit, may be billed without PA if the recipient's service limits have not been used.

If PA is requested after the 5th visit, the physician order and therapist evaluation will be required for review. If DMAS criteria and program guidelines are met, authorization will begin on the date that the PA is requested.

Recertification Review

Prior to the end of the last PA date, or the next visit, the provider must submit the plan of care for continued PA. This plan of care will be reviewed to determine if DMAS criteria and documentation requirements are met. Documentation requirements are located in Chapter VI of this manual. Plans of care must include the physician's dated signature. The DMAS PA contractor will make a decision to approve, pend, deny, or reject the request. If the request is approved, DMAS or the PA contractor will authorize a specific number of units and dates of service.

Facsimile Preauthorization (PA)

Request for PA may be submitted via facsimile using the new DMAS-351 (R 06/03). Refer to the Exhibits section of this chapter for a copy of the form and the instructions. The provider must attach the required documentation as described above. If the request is approved, DMAS or the PA contractor will authorize a specific number of units and dates of service. The revised version of the DMAS-351 form may be obtained on the DMAS website at www.dmas.virgina.gov (***please note the new website address***). This new DMAS-351 form will assist the DMAS PA contractor in processing provider initial and recertification requests.

804-648-6880 Fax Number for Richmond Area
888-243-2770 Fax Number for All Other Areas

Telephonic Preauthorization

To make a telephonic request, providers call the DMAS PA contractor and provide the information requested to the PA analyst. The provider should have the clinical record on hand before calling the DMAS PA contractor for preauthorization. Additionally, the provider will need to verify that the required documentation and justification exists in accordance with federal

and state regulations, and DMAS published criteria, policy, and procedures.

When telephonic preauthorization is requested, the DMAS PA contractor will inform the provider of the status of the request (approve, pend, deny, reject). The provider will also receive confirmation of the decision in writing. While the provider is on the telephone, the DMAS PA contractor analyst may assign the provider a treatment authorization number (tracking number) for the services requested. If the request is approved, the DMAS PA contractor will indicate the units and dates of service approved. If treatment is needed beyond the previously approved time frame, the provider must call and request preauthorization prior to the end of the previously approved time period. If the request is pended, the DMAS PA contractor will mail the provider a pend letter describing the additional information requested, which the provider must submit within 30 days of receipt of the pended notification. If the pend response is not received within 30 days, the request will be rejected or denied. If the request is denied, the provider may request reconsideration as described in this section of the chapter. If the request is rejected, the provider must call in a new request, with the rejected issues addressed and corrected.

Telephonic preauthorization requests must be made directly to DMAS PA contractor at the following telephone numbers:

(804) 648-3159	Richmond Area
(800) 299-9864	All Other Areas

Paper Preauthorization

The only exception to telephonic preauthorization is in cases of retroactive eligibility. The provider may request retroactive preauthorization in writing on the DMAS-351 form with supporting documentation.

To submit a preauthorization request on paper (only for retroactive eligibility requests), mail the DMAS-351 form and supporting documentation to FIRST HEALTH Services Corporation, the DMAS fiscal agent. The address is:

Virginia Medical Assistance Program
P.O. Box 25507
Richmond, VA 23261

All providers must mail pend responses to paper preauthorization requests directly to the DMAS PA contractor. The address is:

WVMI
6802 Paragon Place, Suite 410
Richmond, Virginia 23230

If the recipient is enrolled in MEDALLION, there must be a referral for the service from the MEDALLION primary care physician (PCP), This referral may be obtained in writing or orally and must be documented in the recipient's record.

DMAS-351 Process

Refer to the "EXHIBITS" section at the end of this chapter for a sample of the current version of the DMAS-351. All preauthorization requests for retroactive eligibility must be submitted using the current revision (6/03) of the DMAS-351. Additional DMAS-351 forms may be obtained by contacting:

Commonwealth-Martin
1700 Venable Street
Richmond, Virginia 23223
Main Tel.#: (804) 780-1700

The Commonwealth-Martin DMAS order desk telephone number is (804) 780-0076. The fax number is (804) 782-9876. Each request form has instructions for completing the DMAS-351 on the reverse side.

Submission of Additional Information

Additional information may be provided via telephone unless otherwise indicated. If the DMAS PA contractor has received a request and determined that additional information is necessary to complete the review process, the provider will be notified by telephone, and/or will be mailed a computer-generated pend letter, identifying the specific information that is needed. The DMAS PA contractor has the option of requesting written information at its discretion. If submitting additional information via telephone, contact the DMAS PA contractor directly. If submitting additional information in writing, return the computer-generated pend letter with the additional information to the address listed on the pend letter.

If submitting additional information in writing, follow the instructions as indicated on the "computer generated pend letter" by attaching the completed DMAS-361 form (R 6/03). Refer to Exhibits at the end of this chapter for a sample of this form and instructions for completion.

It is the responsibility of the requesting provider to coordinate and submit the additional information that has been requested. Additional information must be submitted within 30 days of the date on the letter. If information has not been received within the allowed time period, the request will automatically be rejected. If the requested service is rejected, but the preauthorization is still needed, a new "original" request must be submitted and all supporting documentation must be attached.

Packages or documents that are received and are not clearly identified will be discarded if they cannot be matched with the original request. When submitting written information in response to a pended request, send the package to:

[1] Providers may begin using the national billing codes for dates of service on or after June 20, 2003. For dates of service on or after January 1 2004, national billing codes must be used. Local/national code crosswalk is available on DMAS website.

WVMI
6802 Paragon Place, Suite 410
Richmond, VA 23230

Handling of Rejected Requests (400 Action Reason Codes)

Reject action reason codes (beginning with a "400") may be applied at several points during the review process either by the fiscal agent or by the preauthorization contractor. The preauthorization request may be rejected for various technical reasons (e.g., incomplete areas). Rejections are not clinical denials and, therefore, cannot be appealed by the recipient or provider.

DMAS-351 forms that do not contain the requesting provider's nine-digit provider number or do not contain the provider number and the twelve-digit recipient identification number, will be rejected before entry into the system. If the requesting provider has written his or her address on the form, the fiscal agent will return the entire package to the requesting provider. This will be the only circumstance in which the DMAS-351 and attachments will be returned to the provider. There will be no record on the automated preauthorization file of these requests ever having been submitted.

Providers will be notified of other reject actions at the point in which the reject action code is applied. The original DMAS-351 submitted will not be returned to the provider when a reject action code is applied. This information will be stored on the automated preauthorization file, and providers may inquire for preauthorization status by contacting the DMAS Provider HELPLINE. Remember that the HELPLINE is for provider use only. Do not give the Provider HELPLINE telephone number to recipients. Recipients may call 804-786-6145.

Action reasons are applied to each revenue code requested. If more than one revenue code is requested, the entire DMAS-351 package may contain multiple action codes (some codes may be denied, others rejected, others pended for additional information, and yet others approved). Reject reasons applied automatically by the system at the fiscal agent's location are done so before the DMAS-351 package is forwarded to the preauthorization contractor for review. Service codes that pass all the system-generated reject and denial edits are forwarded to the preauthorization contractor for staff review. The preauthorization contractor will not review those service codes that have been rejected or denied by automated system edits.

Once the provider receives a reject reason for a requested revenue code, the provider must submit a new DMAS-351 (R 6/03) package and indicate that it is an "original request" in order to have the service preauthorized. The new package must contain all necessary supporting documentation. The provider may not bill a recipient for covered services if the preauthorization package is rejected with a reject reason code.

No alternate versions of the DMAS-351 (R 6/03) may be used (such as computerized). Only the originals supplied by DMAS or photocopies will be accepted unless previously approved by DMAS.

All of the services requested on one DMAS-351 (R 6/03) will be treated as one PA request and will be assigned the same tracking number. This tracking number must be entered on the claim submitted for these items. Only one tracking number will be permitted for each claim.

RECONSIDERATION AND APPEALS PROCESS

If rehabilitation services are denied by the PA analyst and the outpatient rehabilitation provider wants to request reconsideration of the denial, the provider must follow the reconsideration process. If a telephone request is denied, the provider may either request telephonic or written reconsideration from the DMAS PA contractor Outpatient Review Services Supervisor within 30 days of the date of the denial. The DMAS PA contractor Outpatient Review Services Supervisor has the option of requiring written reconsideration of a telephone preauthorization request. To request reconsideration of a denied request, the provider must submit a letter of reconsideration within 30 days of the notice of denial, to:

WVMI
Outpatient Review Services Supervisor
6802 Paragon Place, Suite 410
Richmond, Virginia 23230

After completion of the reconsideration process, the denial of preauthorization for services not yet rendered may be appealed in writing by the Medicaid recipient within 30 days of the written notification of denial. If the preauthorization denial is for a service that has already been rendered, the provider may appeal the adverse decision in writing within 30 days of the written notification of denial of the reconsideration. Written appeals must be addressed to:

Director, Appeals Division
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

The provider may not bill the recipient for covered services that have been provided and subsequently denied by DMAS or the PA contractor.

Recipient Appeals

If the denied service has not been provided, the denial may be appealed by the recipient or by the recipient's authorized representative. For additional information on recipient appeals, refer to the appeals section of Chapter VI of this manual.

GENERAL INFORMATION

Medicare Catastrophic Coverage Act of 1988

The Medicare Catastrophic Coverage Act of l988 and other legislation require State Medicaid Programs to expand the coverage of services to certain low-income Medicare beneficiaries, known as Qualified Medicare Beneficiaries (QMB's).

QMB Coverage Only

Recipients in this group are eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit, less the recipient's copayment on

allowed charges for all Medicare-covered services. Their Medicaid verification will provide the message "QUALIFIED MEDICARE BENEFICIARY--QMB." The Medicare coinsurance is limited to the Medicaid fee when combined with the Medicare payment.

QMB Extended Coverage

Recipients in this group will be eligible for Medicaid coverage of Medicare premiums and of deductible and coinsurance up to the Medicaid payment limit on allowed charges for **all** Medicare-covered services **plus** coverage of **all** other Medicaid-covered services listed in Chapter I of this manual. This group's Medicaid verification provides the message, "QUALIFIED MEDICARE BENEFICIARY--QMB EXTENDED." These recipients are responsible for copays for pharmacy services, health department clinic visits, and vision services.

All Others

Recipients without either of these messages on their Medicaid cards will be eligible for those covered services listed in Chapter I of this Manual.

EXHIBITS

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST

1 Original ☐ 2 Cancel ☐ 3 Change ☐

Page _____ of _____

SERVICING PROVIDER INFORMATION

Number 4

Name 5

Contact Person 6

Phone 7

Enrollee ID# 8

Enrollee Name:

Last 9

First 10

MI 11

Referring Provider # 12

13 ☐ Other Non-Paper Enclosure 14 ☐ X-Rays Enclosure 15 ☐ Photographs Enclosure

Diagnosis Code 16

PA Number 17 (If cancellation or Change)

PA Service Type 18

1	19 ☐ 20 ☐	HCPCS/CPT Revenue Code	21		22					Units requested 23 Amount Requested 24			
	Desc 25									Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY)	FROM 27								To 28			
2	19 ☐ 20 ☐	HCPCS/CPT Revenue Code	21		22					Units requested 23 Amount Requested 24			
	Desc 25									Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY)	FROM 27								To 28			
3	19 ☐ 20 ☐	HCPCS/CPT Revenue Code	21		22					Units requested 23 Amount Requested 24			
	Desc 25									Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY)	FROM 27								To 28			
4	19 ☐ 20 ☐	HCPCS/CPT Revenue Code	21		22					Units requested 23 Amount Requested 24			
	Desc 25									Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY)	FROM 27								To 28			
5	19 ☐ 20 ☐	HCPCS/CPT Revenue Code	21		22					Units requested 23 Amount Requested 24			
	Desc 25									Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY)	FROM 27								To 28			
6	19 ☐ 20 ☐	HCPCS/CPT Revenue Code	21		22					Units requested 23 Amount Requested 24			
	Desc 25									Line # If Requesting Cancellation Or Change) 26			
	Dates of Service requested (MM/DD/YY)	FROM 27								To 28			

FOR ADDITIONAL PROCEEDURES FOR THE SAME PA#, USE AN ADDITIONAL FORM – ENTER BOXES 4,5,12,13,14, AND 1 ON EACH ADDITIONAL FORM

29 Provider Signature _____ 30 Date Signed _____

DMAS -351 R 6/03

Instructions For Completion of the DMAS-351 – Virginia Department of Medical Assistance Services "Prior Review and Authorization Request" Form

The DMAS-351 is to be used when requesting a new prior authorization, to request a change an existing authorization, or to cancel an existing authorization. Note: A cancellation request can only be honored if there has been no claims activity posted against the authorization.

HEADER DATA

1 – 3	Put an "X" in the box next to the type of request being submitted.
4 – 7	Servicing Provider Information: includes provider ID #, name, a contact person's name, and telephone number.
8 – 11	Enrollee (Patient) Information: includes enrollee ID#, last name, first name, middle initial.
12	Referring Provider ID # (if applicable).
13 – 15	Indicate if attaching a non-paper enclosure, x-ray, or photograph for review.
16	Enter the primary diagnosis code for the enrollee.
17	Enter the PA Number (tracking number) if requesting a change or cancellation.
18	Enter the appropriate PA Service Type. (See listing in Provider Manual with these instructions).

LINE ITEM DATA

Each form will accommodate up to 6 lines of requests for authorization of services or equipment. If more than 6 lines are needed, use additional DMAS-351's to request additional services or equipment. Be sure to indicate the number of the pages being submitted (top right), especially if more than one DMAS-351 is required.

19 – 25	Indicate the type of procedure code, the procedure code, up to 4 modifiers (if applicable), the number of units requested, amount requested, and a description of the item/service requested.
26	Enter the line # for which you are requesting a change or cancellation.
27 – 28	Enter the From Date and To Date of Service
29 – 30	Provider's signature and date signed.

ATTACHMENTS

Attach required and supportive medical documentation to the completed DMAS-351 and submit to:

Virginia Medical Assistance Program
P.O. Box 25507
Richmond, VA 23261

VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES
PRIOR REVIEW AND AUTHORIZATION REQUEST
SUPPORTING DOCUMENTATION

1 ☐ Return Pend Documentation
2 ☐ Request for Reconsideration
(Check only (1) box)

Pending or Denied PA # (if known)
3 _____

4 Check appropriate box(es)

Line 1 ☐	Line 2 ☐	Line 3 ☐	Line 4 ☐	Line 5 ☐	Line 6 ☐
Line 7 ☐	Line 8 ☐	Line 9 ☐	Line 10 ☐	Line 11 ☐	Line 12 ☐
Line 13 ☐	Line 14 ☐	Line 15 ☐	Line 16 ☐	Line 17 ☐	Line 18 ☐

PROVIDER INFORMATION

Number: 5 _____

Name: 6 _____

Contact Person: 7 _____

Phone: 8 _____

Enrollee ID# : 9 _____

Enrollee Name:

Last: 10 _____

First: 11 _____

MI: 12 ☐

13 ☐ Other Non-Paper Enclosure
14 ☐ X-Rays Enclosed
15 ☐ Photographs Enclosed
16 ☐ Dental Models Enclosed

PA Service Type: 17 _____

18 COMMENTS: _____

THIS IS TO CERTIFY THAT THE FOREGOING AND ATTACHED INFORMATION IS TRUE, ACCURATE AND COMPLETE, ANY FALSE CLAIMS, STATEMENTS, DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT, MAY BE PROSECUTED UNDER APPLICABLE FEDERAL OR STATE LAWS.

19 Provider Signature _____ 20 Date Signed _____

DMAS - 361 R 6/03

Instructions For Completion of the DMAS-361
Virginia Department of Medical Assistance Services
"Prior Review and Authorization Request Supporting Documentation"

The DMAS-361 is to be used when returning requested documentation in response to a pend, to request reconsideration of an adverse prior authorization decision, or if sending in orthodontic models separate from the prior authorization request. This form and applicable attachments should be submitted to:

Virginia Medical Assistance Program
P.O. Box 25507
Richmond, VA 23261

INSTRUCTIONS BY INDICATOR NUMBER:

1. Return Pend Documentation:	Mark with an "X" if returning documentation in response to a pend.
2. Request for Reconsideration:	Mark with an "X" requesting reconsideration in response in response to an adverse prior authorization decision.
3. Pending or Denied PA#:	Enter the PA or Tracking Number (if known). If sending in orthodontic models for authorization, leave this field blank.
4. Check appropriate box(es):	Identity which line(s) of the Prior Authorization to refer to.
5. Provider Number:	Enter the provider's Medicaid ID #.
6**.** Name:	Enter the provider's name
7. Contact Person:	Enter a Contact's name representing the provider.
8. Phone:	Enter the telephone number at which the Contact can be called.
9. Enrollee ID #:	Enter the enrollee or patient's Medicaid ID#
10—12 Enrollee Name:	Enter the enrollee for patient's last name, first name, and middle initial.
13—16 Enclosure Type:	Enter an "X" in the appropriate box to indicate enclosure type.
17. PA Service Type:	Enter the appropriate PA Service Type. (See listing in provider manual).
18. Comments:	Enter any comments that provide clarification or further
19. Provider Signature & Date	The provider must sign and date the form.

OPTIONAL REHABILITATION SERVICES FORMS

Following are samples of three optional forms for use by outpatient rehabilitation service providers. The first is the Outpatient Rehabilitation Plan of Care form, which may be used by outpatient rehabilitation providers. The plan of care is not a required form. However, the components outlined on the form are required components of an outpatient rehabilitation plan of care as indicated in this manual.

The Outpatient Rehabilitation Plan of Care Addendum form may be used for additional documentation that continues from the first page of the plan of care or it may be used for changes in the physician's order such as changes to frequency or duration of services, long-term goals, or a significant change in the recipient's condition.

The Progress Report form may be used for preauthorization purposes when requesting extended outpatient therapy visits. The form may also be used when revising short-term goals and when updating progress during the annual plan of care certification period.

These forms may be scanned into a computer or copied for provider use.

Department of Medical Assistance Services
Optional Outpatient Rehabilitation Plan of Care

Effective dates of Plan of Care: ___/___/___ to ___/___/___

Recipient Name: (as it appears on the Medicaid card)	Medicaid Number: (12 digits)	Date of Birth:
Provider Name:		Medicaid Provider Number: (9 digits)

PLAN OF CARE (For the first plan of care, check 'initial'; for subsequent plans of care, check 'recertification')	Initial _____	Recertification (subsequent plan of care) _____

SERVICES: Check one of the following: PT, OT, SLP. Provider must complete a separate plan of care for each discipline.
PT_____ OT_____ SLP_____

Service History: How long has the recipient received services from your agency?

How long has recipient received therapies from this service for this treatment diagnosis?

Primary diagnosis and date of onset (provide text and ICD-9 code):

Treatment diagnosis and date of onset. Enter the diagnosis for which services are rendered (provide text and ICD-9 code). If the same as the primary diagnosis, enter "same".

Assessment of recipient: Enter the recipient's functional level and reason for beginning or continuing therapy. Enter the major functional limitations in objective, measurable terms. Include relevant surgical procedures, prior hospitalization and/or therapy for the same condition. Include baseline measurements for goals written below from which to determine progress or lack of progress in the future.

Progress (for recertification): Include recipient's progress towards goals and patient response to treatment during the last treatment period. Describe progress in objective measurable terms.

Long-term goals: Enter measurable, functional, patient-oriented long-term goals. Include time frames for goal achievement.

Short-term goals: Enter measurable, functional, patient-oriented short-term goals. Include time frames for goal achievement. Short-term goals must be steps towards achieving the long-term goals.	
Plan/Modalities: Enter the rehabilitation treatment procedures or modalities that are to be used by the therapist.	
Frequency and Duration: Enter the frequency of treatment to be rendered (e.g., 3x/week). Include an estimate of the duration, length of time, the services are to be rendered (not per session).	Individual Frequency: _____ Group Frequency: _____ If frequency is for individual and/or group check here ___ Duration: _____
Coordination of services: Is the recipient receiving services from other agencies? If so, services must be coordinated between the agencies. Specify the other agencies involved in the recipient's care and efforts to coordinate services (e.g., correspondence, telephone calls between school therapists or agency therapists, etc.). There must be demonstrated coordination between the agencies involved in the recipient's care.	
Discharge Plan/Estimated Discharge Date: Enter the estimated date of discharge from services for the recipient. Also, include anticipated functional levels at discharge and need for future services.	
Therapist Signature: Qualified therapist must fully sign and date the plan of care.	**Date**:
Physician Signature: Physician must review, and fully sign and date the plan of care within **21 days** of the implementation date of the plan of care. _____ **I certify that the above treatment is medically necessary**.	**Date**: (Physician must date his/her own signature)

Department of Medical Assistance Services
Optional Outpatient Rehabilitation Plan of Care
Addendum
Effective Date: _____/____/_____

Addendum must be completed when there is a change in frequency or addition of long-term goals. (If all long term goals have been completed a new plan of care must be written on the Plan of Care form). To update patient progress or short-term goals use the Outpatient Rehabilitation Progress Report.

Recipient Name:	Medicaid Number: (12 digit)	Date of Birth:
Provider Name:	Provider Number: (9 digit)	

Service: PT_____ OT_____ SLP_____

Assessment of recipient (continued): Include reason for need to change frequency or need to add, change, or delete long-term goals. Document any changes in the recipient's functional limitations, test results, recent surgery or hospitalization.

Additional long-term goal(s) with time frame(s) for goal achievement: Enter measurable, functional, patient-oriented long-term goals.

Additional short-term goal(s) with time frame(s) for goal achievement: Only list short-term goals related to new long-term goals above. Short-term goals must be measurable, functional, and patient-oriented.

Plan/Modalities: related to new long-term goals above.

Frequency And Duration: If changed from the original plan of care, enter the frequency of treatment to be rendered (e.g., 3x/week). Include an estimate of the duration, length of time, the services are to be rendered (not per session).	Individual Frequency: _____ Group Frequency: _____ If frequency is for individual and/or group check here ___ Duration: _____

Therapist Signature:	**Date**:
Physician Signature: _____ **I certify that the above treatment is medically necessary** Addendum must be signed within **21 days** of the effective date of the addendum in order to be valid from the effective date at the top of the page.	**Date**: (Physician must date his/her own signature)

Outpatient Rehabilitation PROGRESS REPORT

To be used with DMAS Annual Plan of Care (Optional)

This form may be used when updating short-term goals and when updating progress during the annual plan of care certification period. This information may be requested for preauthorization if the information on the annual plan of care is not the most current information.

Recipient Name:	Medicaid Number: (12 digit)	Date of birth:
Service: PT_____ OT_____ SLP_____		
Progress: Progress period _____ to _____ (Enter full month, day, year). Enter the recipient's current functional level and reason for continuing therapy. Include recipient's progress towards goals and response to treatment during the last treatment period.		
Updated short-term goals with time frames for goal achievement: Enter measurable, functional, patient-oriented short-term goals. Include time frames for goal achievement. Short-term goals must be steps towards achieving the long-term goals.		
Plan/Modalities: Complete if changed from the plan of care or last progress report. If not applicable indicate "N/A."		
Coordination between agencies: Complete if changed from the plan of care or last progress report. See plan of care for instructions. If not applicable indicate "N/A."		
Other:		
Therapist Signature:		**Date:**